safe & sound

Dudley's Community Safety Partnership

Executive Summary of the Multi-Agency Review into the death of 'Charlie'[1]

In August 2021

Report produced for Dudley Safe and Sound by
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Independent Chair and Author
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[1] pseudonym

Contents

1. The Background

1.1. This review concerns the circumstances leading to death of Charlie, a 22-year-old woman and mother of a 2-year-old child. Although at the time of writing, the inquest into Charlie's death is awaited, the cause of death was thought to be from suicide. A criminal investigation found no evidence that any other person was involved in her death. However, it was known that Charlie experienced domestic abuse in her relationship.

1.2. Charlie grew up in a secure family home and was described by her family as a kind and gentle soul who always looked for the good in people. She met her partner online during her first year of sixth form in 2016. He was one year older than her and was her first boyfriend and vice versa.

1.3. From the early days of their relationship, her partner was observed to be controlling of Charlie: constantly calling and messaging her, monitoring her movements and telling her what to wear. As the relationship progressed, she spent more time with her partner and his friends, and his physical violence began.

1.4. Her partner experienced the suicide of his brother shortly before Charlie's death.

2. Summary of Chronology

2.1. Charlie had always been a highly motivated and hard-working young woman and commenced a degree course in September 2018. During her first year, when aged 19, she became pregnant and did not return to University. She was still working part-time and told a work colleague that she wanted a termination, but her partner would not let her.

2.2. Later in her pregnancy, Charlie was supported by a specialist perinatal mental health midwife as she was feeling low in mood and becoming withdrawn and socially isolated. She felt no connection with the baby and was undecided if she wished to keep it when it was born.

2.3. In May 2019, Charlie attempted suicide by taking an overdose. She told hospital staff that the overdose as a "cry for help" because of "increasing family issues" and feeling "unable to cope." Safeguarding referral were made to adult and children's services.

2.4. Charlie told her GP that she got on well with her partner and was protective to the baby. She was prescribed anti-depressant medication and referred to a local family support service. Although there was a 12 week gap in health visiting services, the GP was persistent in seeking engagement with Charlie until she moved out of the catchment in September 2019.

2.5. After the move, Charlie told health visitors that she was feeling better, and she was working as a 101 call operator for the Ambulance Service. She was routinely asked about domestic abuse a number of times which she denied, and the child was assessed as needing only universal health services.

2.6. After the pandemic started, in August 2020, Charlie's partner called the police the police and Charlie told them that her partner had kicked her in the stomach, and she responded by slapping him across the face. She declined to make a formal complaint but was assessed as facing standard risk. The incident was considered by the multi-agency Domestic Abuse Response Team (DART) and the family were referred to the health visiting team and family support worker for early intervention, and to CHADD for domestic abuse support, but CHADD did not appear to have received the referral.

2.7. Family Support were unable to contact Charlie and closed the case. Health visitors made contact with her six weeks later and Charlie minimised the reported domestic abuse, describing it as an argument and declined further support. However, Charlie told her friend how her partner had beaten her.

2.8. During the night, in January 2021, a silent call was made to the police, but in the background a man could be heard shouting at a child, and a woman was crying. The police tracked the phone to Charlie's parents, twenty miles away, but were diverted to an incident requiring an immediate response and were not able to return to Charlie's address again until the next morning. Charlie stated that the police had been called by mistake, that she had only a minor bruise and she declined to make a complaint. She was assessed as standard risk.

2.9. The DART referred her to the MASH and the IDVA and Charlie told each agency that she just wanted help for her partner whose mental health had been suffering since lockdown. Charlie agreed to accept support from Early Help services and the IDVA. Early help was also to speak with her partner concerning his mental health and the impact of domestic abuse upon his family. The health visitor was unsure who should take the lead on the early help work.

2.10. There was then a five week delay before the family support worker contacted Charlie, who by that time advised that she no longer needed support with her relationship. There was a further gap of eight weeks, before the Early Help Assessment was undertaken with a joint visit with a new family support worker and the health visitor and the assessment concluded that there were any concerns that could not be met by universal health visiting services.

2.11. In July 2021 Charlie moved back to her parent's home saying that there were too many problems in the house that she shared with her partner, and they could not afford it. and started working at a veterinary surgery. She had also enrolled at Wolverhampton University to study animal behaviour.

2.12. Charlie re-registered with her former Birmingham GP Practice. She had not been registered with any GP whilst in Dudley, so they were not aware of concerns in the

family. There was then a delay whilst health visitors in Dudley handed over details of her case, including details of the early help assessment and reports of domestic abuse, to Birmingham health visitors who were also not aware of the concerns in the family.

2.13. On the day before her death, Charlie was staying with her partner but had spoken with her mother about the escalating abuse. She was ambiguous about whether she intended to make the separation permanent. Her mother had advised her to throw things into plastic bags and they would fetch her, which she appeared to have done.

2.14. She was found deceased by her partner who told the police that she had wanted to reconcile but he felt they were rushing into it. Charlie's family, however, were concerned that she had showed no signs of suicidal thoughts and had been planning ahead. They considered that there were signs of a violent argument in the car and were surprised that the property was in such a state. They made allegations of her partner's coercive control of Charlie during their relationship, but the police were not able to find evidence to substantiate the allegation.

3. Key Findings

3.1 Indicators of Domestic Abuse

3.1.1 Although neither Charlie's family and friends, nor any individual agency, knew the whole picture, there were indicators of abuse that were not fully explored by agencies. We now know from Charlie's testimony that she was subjected to

- Physical violence: being beaten and kicked in the stomach
- Coercive control and surveillance: her movements were monitored; she had to check in with him constantly; he told her what to wear and she ''trod on eggshells around him
- Reproductive coercion: he would not let her terminate the pregnancy and although she did not appear to tell professionals they did not always routinely ask about domestic abuse

Learning Point: Reproductive Coercion
Practitioners must always consider the possibility of reproductive coercion when a teenage woman becomes pregnant. Health practitioners should routinely ask about domestic abuse, recognising the additional barriers that young women will face in being able to disclose their abuse.

- Economic abuse: Charlie unexpectedly dropped out of university after her child was born despite declaring her intention to return, and her family thought that it was because her partner did not like her attending

> **Learning Point: Educational Sabotage**
> By disrupting an individual's ability to gain educational qualifications, a domestic abuser extends their power and control over their partner. Tactics of educational sabotage could include telling a victim that they will fail; undermining a victim's abilities; demeaning their educational goals; controlling access to college; interfering with studying or doing homework; making a partner feel guilty for spending too much time on study; responding with jealousy, resentment and insecurity.

- There were other indicators of economic abuse present: Charlie was unable to continue to share a home with her partner because of financial problems and she had told her colleagues in the Ambulance Service that she had financial worries after her first suicide attempt. Practitioners need to be alert to indicators of economic abuse as economic abuse rarely occurs in isolation from wider forms of domestic abuse
- Separation: Charlie had recently taken steps to separate from her partner

> **Learning Point: Separation and help-seeking are dangerous periods** for victims of domestic abuse. For a perpetrator, their victim's help-seeking or separation represents their loss of control over them, and their violence and abuse often escalates as they try to re-establish their control.

3.2 Suicide and Domestic Abuse

3.2.1 Several agencies did not identify the links between suicide and domestic abuse

> **Learning Point: Suicide & Domestic Abuse**
> Coercive control, isolation and entrapment are tactics of perpetrators of domestic abuse which can lead to low self-worth, hopelessness, despair and suicide in their victims.
> Women presenting to services in suicidal distress or after self-harm should always be asked about domestic abuse.

3.2.2 Charlie's suicide occurred not long after her partner's brother, who was from a settled Traveller community, died by suicide. There are high levels of suicide within the Travelling community.

Learning Point: Exposure to Suicide Can Increase the Risk of Suicide
For some individuals, being exposed to a suicide death can provide an increased awareness of suicide as 'something that actually happens,' as well as 'something they too could do'. This will depend on the meaning that the individual makes of the experience and the context surrounding the death.

3.3 Barriers to Engagement

3.3.1 There were several times when Charlie declined to disclose the domestic abuse that she was experiencing, or she minimised and excused the abuse. There will be many reasons why women experiencing domestic abuse may not feel able to disclose their experiences and agencies experience barriers in engaging with a victim. These could include a victim's overwhelming fear of the perpetrator and a lack of understanding and uncertainty about agencies. Barriers can also be experienced as a result of a practitioners' lack of understanding about domestic abuse and coercive control, or in the manner in which they engage with victims. For Charlie, we found that she was frightened of her child being taken away from her.

Learning Point: Overcoming Fears
Victims of domestic abuse often fear that their children will be taken away by children's services, despite this being far from practitioners' minds. They will often have been told by their abusers that they are poor mothers and unable to cope without them, particularly if the abuse has already affected their mental health. Fears of child removal may be particularly prevalent in some minoritised communities, such as traveller families.
Practitioners need to be aware that these fears are common and work hard to dispel common myths, whether or not expressed, and promote confidence in agencies' desire to protect and support victims of domestic abuse to care for their children and keep the family safe.

3.3.2 At times, Charlie was encouraged to approach domestic abuse services. On one occasion the domestic abuse service did not appear to have received the referral.

Learning Point: Active Referrals
Accessing specialist domestic abuse services may feel daunting and overwhelming for victims of domestic abuse. Agencies need to consider how they let victims know about support exists and how they can support victims with active referrals.

3.3.3 There were several times when agency actions to engage with Charlie were delayed due to staff absences and Charlie no longer wanted their support when contacted.

Learning Point: Timely Engagement
The timing of our attempts to engage with a victim of domestic abuse is important. Victims face innumerable barriers to seeking help but when they reach out to services it will often be at times of crisis or significant threat.
In the absence of an immediate response, the barriers that they face will start to surface again. For example, the perpetrator will have more time to prey upon the victim's fears, provide excuses for their behaviour or show remorse. This often results in a victim declining further support or minimising their abuse

3.3.4 There were several periods where agencies were trying to contact Charlie without success. During many of these times, Charlie was working night shifts and was was also living between three homes. As a result, the standard approach of engaging with her would not have been effective.

Learning Point: How flexible and responsive are our services?
Many victims, because of work or other commitments, do not fit the model of working that is preferred by agencies. Do agencies have the opportunity to reflect when they are unable to make contact with a victim of domestic abuse and consider of there are specific circumstances that they need to consider and adapt to?

3.3.5 There were several times when practitioners did not exercise professional curiosity when they had contact with Charlie such as after her overdose and panic attacks; when she minimised the abuse or during the Early Help Assessment.

Learning Point: Professional Curiosity in Domestic Abuse
A robust understanding of domestic abuse is needed for assessments and responses to be effective. Practitioners need to understand the complex and nuanced pattern of coercive control in order to understand their own challenges to engage with victims and, for example:

- Why victims may minimise or deny the abuse they are experiencing
- How perpetrators intimidate, isolate and control their victims, stripping away their sense of self (Stark 2007:5)
- The impact that living with persistent fear, undermining, gaslighting may have on a person's mental health

3.4 Mental Health and Domestic Abuse

3.4.1 There were several occasions when Charlie declined help for herself but told professionals, who were responding to the domestic abuse, that she just wanted her partner to receive help for his mental health. It appeared that she interpreted, or perhaps hoped, that his abusive behaviour was a symptom of his mental health.

> **Learning Point: Mental Health is not a Cause of Domestic Abuse**
> It is the responsibility of all practitioners to engage with victims of domestic abuse and sensitively challenge their misconception that their partner's mental illness is causing their abusive behaviour.
> Domestic abuse victims need to understand that their abusers are responsible for their own behaviour in order that victims can effectively make safety plans for their own, and their children's, safety.

3.5 Domestic Abuse in the Traveller Community

3.5.1 Charlie's partner belonged to a family of settled travellers. It is not known how much he was influenced by traditional cultural expectations of gender roles and family honour. However there was a history of domestic abuse in his wider family.

> **Learning Point: Domestic Abuse in Gypsy, Roma and Traveller Communities**
> Whilst domestic abuse affects women from all ethnic and social groups, it is most commonly experienced within relationships or communities where there is support for strongly hierarchical or male dominated relationships, where male authority over women and children is culturally expected and condoned, and where there is a strong sense of family honour, such as in more traditional Gypsy, Roma and Traveller Communities. However, attitudes towards women amongst younger generations of Traveller communities are seen to be changing (Traveller Movement, 2017).

3.6 Young Victims of Domestic Abuse

3.6.1 Charlie began her relationship with her partner, her first relationship, whilst still a teenager and we have seen that she was subjected to coercive control very early in the relationship.

> **Learning Point: Young People** may not understand what constitutes abusive behaviours and, having less experience of relationships, were more likely to normalise abuse, possibly misconstruing controlling or jealous behaviour as love (Home Office, 2021).

3.7 Invisible Abusers

3.7.1 Throughout agency attention over the safety and well-being of the child, the emphasis was on Charlie's parenting and her responsibility alone to work with agencies rather than on the child's father to stop the domestic abuse. Although a family support worker made attempts to contact her partner by phone without success, there were indicators that staff may have been reticent about contacting a father who perpetrates domestic abuse for fear of triggering his violence towards the mother and putting her more at risk.

Learning Point: Invisible Fathers

In our assessments of children at risk or in need, it is more often the mothers' ability to keep children safe that has been the focus of agency attention, rather than the assessment and planning around the perpetrator of domestic abuse, usually the father. There may be many reasons for this. For example, sometimes the perpetrator deliberately hides from agency gaze; sometimes practitioners may be wary of provoking more domestic abuse by involving or confronting him; sometimes practitioners may be frightened themselves of an abuser.

Domestic abuse is a parenting choice of the perpetrator. Exposure to parental domestic abuse is domestic abuse of the child. Intervention is needed with the perpetrator to reduce the risk and harm to the child and mother through engagement, accountability and civil and criminal justice.

3.8 Crossing Boundaries

3.8.1 Charlie moved between Birmingham and Dudley, and there was a delay in providing health visitors in Birmingham with all the details of the history of domestic abuse and mental ill-health in the household.

Learning Point: Continuity of Health Visiting Care Across Borders

Victims of domestic abuse will often have to move across local authority boundaries in order to find somewhere safe to live. Verbal communication prior to the transfer of records from one area to another is vital in ensuring safe continuity of care for the child and ensure that the family's needs and risks can be picked up in real time when they move home.

3.9 The Impact of Covid-19

3.9.1 After Covid, more of Charlie's appointments and assessments were over the telephone, which may have hindered her ability to disclose domestic abuse.

Learning Point: Safe Enquiry
Health and social care services have made great strides in embedding safe enquiry about domestic abuse into their practice, whether this be routine, targeted or selective enquiry. However, following the Covid pandemic, more appointments, consultations and assessments are held remotely, and practitioners will be following the guidance requiring them to be sure that it is safe to make these enquiries on a case-by-case basis. Far fewer survivors of domestic abuse will now be asked about domestic abuse and agencies need to consider how they can maximise enquiry and mitigate risk.

4 CONCLUDING REMARKS

4.1 This review has considered the experiences of Charlie, a young woman experiencing domestic abuse and young motherhood in her first relationship and whose mental health suffered as a result with tragic consequences.

4.2 When examining agency responses, it can be seen that there were certainly pockets of good practice in agency responses to Charlie including the police's initial attempts to locate Charlie after a silent call had been made; the GP's pro-active and multiple attempts to contact Charlie after she had taken an overdose and the perinatal mental health midwife's engagement with Charlie whilst she was pregnant. However, when viewed collectively, we can see that this young, abused mother was let down by delays in services and by practitioners lacking the professional curiosity, knowledge and skills to explore what was really happening in her relationship and to sensitively confront her when she felt it necessary to minimise the abuse. In the absence of this assertive approach to domestic abuse, and inability to engage effectively with Charlie, assessments downplayed the risk that she faced and the needs of this young mother, who had asked for help, were not recognised as she moved between these two areas in the West Midlands.

5 RECOMMENDATIONS

5.1 Overview & System Recommendations

Recommendation 1: Police response times

Dudley Safe and Sound to seek from West Midlands Police and Crime Commissioner an analysis of West Midlands Police response times for domestic abuse incidents.

Recommendation 2: Suicide and Domestic Abuse

Dudley Safe and Sound to promote the connection between suicide and domestic abuse with the Dudley Suicide Prevention Partnership and jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

- "Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
- Ensure your local Real Time Suicide Surveillance system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
- Ensure domestic abuse training is completed by all mental health staff. (Consider making this a commissioning condition).
- Ensure mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).
- Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped.
- Undertake a detailed analysis of RTSS
- Undertake a detailed analysis of data held by Mental Health Services
- Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods)….
- Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator." (Kent and Medway Public Health, 2022)

Recommendation 3: Exposure to Suicide

Dudley Safe and Sound to forge links with the Black Country Healthcare NHS Foundation Trust and support the Trust in its endeavour to secure 'real-time-surveillance' data on suicide and supports the Trust to development a plan to promptly deliver support to family and friends, as appropriate.

Recommendation 4: Suicide amongst Gypsy, Roma, Traveller Communities

Dudley Safe and Sound to share the report of this review with Dudley Suicide Prevention Partnership to ensure that the heightened risk of suicide amongst Gypsy,

Roma, Traveller Communities and the ramifications of suicide are illustrated and feeds into the Suicide Prevention Strategy.

Recommendation 5: Referrals from DART

Black Country Women's Aid and CHADD to provide assurance to Dudley Safe and Sound that the pathway for referrals to specialist domestic abuse services from DART are effective and that there is feedback provided where engagement has not been possible with a victim of domestic abuse.

Recommendation 6: Coercive Control

Dudley Safe and Sound to seek from partner agencies (i) how they are promoting an understanding of coercive control within their workforce and (ii) what impact their workforce development on coercive control has had on their practice, including the impact upon the identification, risk assessment and response to domestic abuse

Recommendation 7: Domestic Abuse in the Traveller Community

Dudley Safe and Sound to ensure that activities to raise awareness and prevent domestic abuse in Dudley also target the Traveller community

Recommendation 8: Teenage Relationship Abuse

Dudley Safe and Sound to continue to provide and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them.

Dudley Safe and Sound to work with further and higher education establishments in their area to:

- promote awareness specifically about domestic abuse in young people's relationships and educational sabotage
- introduce direct questioning on domestic abuse when a pregnancy is disclosed by a young woman
- promote the specialist services that are available to those experiencing domestic abuse across the age range
- monitor the outcomes of their awareness raising in further and higher education through increased disclosure of domestic abuse by young people, recognising that domestic abuse is under-reported in this age range

Recommendation 9: Crossing Boundaries

Dudley Safe and Sound to share this report with Birmingham Community Safety Partnership to ensure that those issues which have relevance can be addressed across the two areas.

Recommendation 10: Undertaking Safe Routine Enquiry

Health and social care services in Dudley to advise Dudley Safe and Sound

(i) how remote working has impacted upon their ability to make safe enquiry into domestic abuse since the Covid pandemic and

(ii) how they now maximise opportunities for routine, selected or targeted enquiry into domestic abuse and mitigate risk.

5.2 Individual Agency Recommendations

5.2.1 Individual agencies have identified the following recommendations for their service.

Adult Social Care

- Develop Suicide Risk Process for front of house and MASH

Black Country Healthcare NHS Foundation Trust

- Health visitors currently document all family concerns on the child's records. Each family member particularly, parents should have their own records where concerns are documented. The records should be linked in the family management section of Rio.
- Risk assessments and care pathways to be routinely reviewed as part of the health visiting holistic assessment following incidents such as domestic abuse, mental health episodes and any other safeguarding concerns or changes in life circumstance that may impact on risk.
- The first domestic incident did not have health representation at the meeting. If there is no health representation at DART meetings there needs to be a clear assurance process in place to ensure all incidents are being disseminated in a timely way and acted upon within the appropriate timescales.
- Joint assessments to be considered if two agencies are involved in DART incidents and the lead agency to be identified and documented in the records

Birmingham Community Healthcare NHS Foundation Trust

- Assurance required within the health visiting service that process is applied when there are workforce absences.
- Safeguarding team to develop guidance for practitioners to apply and support professional curiosity practices. A working group to be commenced, lead by safeguarding head of service and named nurse safeguarding children to support the development of an aide memoir to enhance clinical practice.
- BCHC practitioners will have access to shared cared records. Access rights and remit are being escalated. This will allow practitioners access to read only information of any child or young person in relation to health and children services.

- Assurance required within Birmingham Forward Steps that the process for reviewing and documenting in records is as per BCHC record keeping policy.

Dudley Children's Services

- Family Support staff absence. Family to be re-allocated if Lead FSW/IFSW is absent from work for longer than 4 weeks.
- If telephone calls are unsuccessful in making contact with families, then consideration be given to undertaking an unannounced visit within an agreed timescale e.g duty visit to take place within one week of the last unsuccessful contact
- Early help services enhance a nuanced understanding of domestic abuse and move beyond an incident-based approach
- Early help services ensure that the perpetrator of domestic abuse is not invisible to assessments over the safety and well-being of the child
- Early help services understand the importance of timely referrals to specialist domestic abuse agencies when consent to do so has been received

Dudley Group NHS Foundation Trust

- To improve awareness in the Emergency Department of Domestic Abuse indicators and selective enquiry.
- Improve effective communication and information sharing between Psychiatric Liaison and DGHNHSFT staff
- Domestic Abuse Policy to be updated to reflect staff responsibilities when patient has taken an overdose, suicidal ideation, suicide attempts or self-harm and consideration around discharge

GP

- Professional curiosity is recognised as vital in completing a holistic assessment and is utilised by GP Practice clinicians

University Hospitals Birmingham

- Routine enquiry should be asked 3 times throughout pregnancy including the postnatal period when the patient is seen face to face, if the patient attends and is accompanied, staff are to try and create an opportunity and safe space to complete routine enquiry

West Midlands Police

- To provide assurance to Dudley Safe and Sound about the accuracy of their risk assessments in domestic abuse

- To report to Dudley Safe and Sound on the impact of the use of the 'child abuse App' on the identification and response to children when responding to domestic abuse incidents
- In order to secure greater engagement of victims with specialist domestic abuse services, West Midlands Police to explore whether adopting the 'opting in' approach, that has been implemented with victims of rape and serious sexual assault, would be similarly effective and could be implemented for all victims of domestic abuse.

Nottingham Trent University

- To introduce direct enquiry on domestic abuse during conversations concerning pregnancy and maternity for affected students.

Appendix: The Review Process

(i) Summary

The decision to undertake a domestic homicide review was made by the Chair of Dudley Community Safety Partnership, and the Home Office was notified of the decision on 30.09.2021. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and all panel members were independent of this case. Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact. The review panel met on five occasions and the Independent Chair met with the victims' family twice. Family members contributed to the terms of reference and considered the draft Overview Report. All comments by the family have been incorporated into the report.

The Overview Report was endorsed by the Dudley Community Safety Partnership on 09.10.23 before being submitted to the Home Office for approval.

(ii) Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Christine Conway	Head of Adult Safeguarding, Dudley MBC Adult Safeguarding
Jane Atkinson	Designated Nurse for Safeguarding Adults, Dudley Integrated Health & Care NHS Trust
Jane Lovell	Team Lead, Adult Safeguarding, University Hospitals Birmingham NHS Foundation Trust
Jean Reid	Head of Supported Housing, CHADD
Julie Mullis	Head of Safeguarding, Dudley Group NHS Foundation Trust
Katriona Lafferty	Community Safety Officer, Dudley MBC Community Safety
Michael Loftus	Lead Nurse Adult Safeguarding, Birmingham Community Healthcare NHS Foundation Trust
Michael Bailey	Detective Inspector, West Midlands Police
Merryn Tate	Head of Adult Safeguarding, Birmingham City Council Adult Social Care
Natalie Solomon	Associate Director for Safeguarding, Black Country Healthcare NHS Foundation Trust
Nicola Hale	Head of Safeguarding, Practice and Quality Assurance, Children's and Young People Safeguarding and Review, Dudley Council Children's Service
Raj Lagan	Regional Head of Domestic Abuse Service, Black Country Women's Aid
Sarah Mantom	Designated Nurse for Safeguarding Adults and Children (Serious Violence Lead), NHS Birmingham and Solihull Integrated Care Board

(iii) Key Lines of Enquiry

The review should focus on events from May 2018 when Charlie began to receive maternity services. Information about earlier times was included for contextual information only.
The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

Individual responses: How effective were practitioners in responding to the needs and risks faced by Charlie and her child and the threat posed by her partner?

- *To provide a pen picture of the victim and her family as known by agencies at the time of contact*
- *To analyse key episodes of agency involvement, to assess what needs, risk and threat each agency identified for the individuals/family and how each agency responded.*
- *How was the support of family, friends and wider networks understood as protective factors?*
- *If domestic abuse was not known, how might practitioners have identified the existence of domestic abuse from other issues presented to them, in accordance with NICE Quality Standard QS116 Domestic Violence and Abuse, available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse? For example, were there policies and procedures for direct, selective or routine questioning and how well were they implemented in this case and the rationale for decision making?*
- *Was the impact of mental health issues and risk of suicide effectively recognised and assessed and what action did agencies take in identifying and responding to these issues, including in compliance with medication?*
- *What barriers to engagement did agencies experience and how did they seek to overcome these barriers?*
- *In what ways, if any, were agencies' response influenced by issues of equality, diversity or vulnerability?*
- *How effective was agency supervision and management of practitioners involved and did managers have effective oversight and direction of the case and on case closure?*
- *Were there any issues in relation to capacity or resources within agencies that affected their ability to provide services to the individuals/family or to work with other agencies, or create delays?*

Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs, within and across borders?

- *How were roles and responsibilities understood and multi-agency protocols adhered to?*
- *Was there a shared ownership and approach?*
- *How effective was the co-ordination of services?*
- *How effective was communication, information sharing and sharing records?*
- *How effective was escalation between agencies?*
- *Did multi-agency systems present difficulties or challenges to the effective delivery of services to members of the family?*

What impact did the Covid pandemic have upon service responses and upon the domestic abuse experienced?

What good practice can be identified?

Are there lessons to be learnt from this case about how practice could be improved?

- *what lessons can be learnt to prevent harm in the future?*
- *How do the circumstances improve our collective understanding of domestic abuse and suicide?*

What recommendations are to be made and how will the changes be achieved?

- *Individual agency recommendations*
- *what system-wide, multi-agency recommendations need to be made?*

In addition, the following agencies are asked to respond specifically in their IMR to the following points in addition to those above:

- Dudley Group and Black Country Healthcare reports to identify who should do routine/selective enquiry on domestic abuse where a victim attends the Emergency Department but is referred swiftly to the psychiatric liaison team.
- West Midlands Police IMR to provide the background of any previous offences and criminal justice outcomes
- Dudley Children's Services and West Midlands Police IMRs to summarise their role in the DART processes in August 2020 and January 2021
- For GPs – how referrals and notifications were followed up

(iv) Agency Involvement in the Review

The following agencies who had had significant contact with the family were asked to contribute an IMR and chronology to the review: Birmingham City Council Adult Social Care, Birmingham and Solihull Integrated Care Board, Black Country Healthcare NHS Foundation Trust, Dudley MBC Children's Services, The Dudley Group and West Midlands Police

The following agencies with some contact, or contextual information concerning the family were asked to provide briefer information reports to the review: Birmingham Children's Trust, Birmingham Community Healthcare NHS Foundation Trust, Birmingham Healthy Minds, Black Country Women's Aid, Dudley Council Adult Services, Dudley Council Housing Services, University Hospitals Birmingham, West Midlands Ambulance Service and Nottingham Trent University.

The following agencies were contacted but confirmed that the family were not known to them, or that their involvement was not relevant to the review: Birmingham Women and Children's NHS Foundation Trust, CHADD, Dudley Integrated Health & Care NHS Trust, Dudley Council Revenues and Benefits and Probation Service